Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0201	A. BUILDING: _____ B. WING _____	C 02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SHELBYVILLE, LLC	835 UNION STREET SHELBYVILLE, TN 37160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments Complaint Investigation #43614, #43681, #43757 and #43830 were completed on 2/26/18 - 2/28/18 at The Waters of Shelbyville. No deficiencies were cited related to the complaint investigation under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	being treated properly and no abuse is occurring. Findings of audits will be reported to the Administrator and DON to follow up on any concerns noted. The IDT consists of the DON, ADON, nurse managers, Social Service Director, Dietary Manager and Activities Director. 4. The results of these audits will be presented by the Administrator monthly to the QAPI committee for further review and recommendation until resolution. The QAPI committee consists of the Medical Director, Administrator, DON, Social Service Director, Activities Director, Dietary Director, and Maintenance/ Housekeeping Supervisor . Completion date 3/12/2018	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/7/18